Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

April 13, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Central Lumbar L5-S1 Epidural Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopaedic Surgeon with over 42 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured after a forklift his him and pushed him from behind and up against several boxes and dragged him for several feet on xx. According to URA report, the claimant received 2 prior lumbar epidural steroid injections. The first one gave 10 percent relief of lumbar pain while the second was given on 9/2013 and only provided temporary relief.

02/18/2013: MRI of Lumbar spine W/O contrast. **Impression:** 1. Diffuse posterior and left foraminal bulge of L4-5 disc, causing mild narrowing of the central canal and neural foramina, bilaterally. The bulge measures approximately 3 mm in size. 2. Diffuse bulge of L5-S1 disc, causing mild narrowing of the central canal and neural foramina, bilaterally. The bulge measures approximately 3mm in size. 3. Diffuse bulge of L2-3 and L3-4 discs, without any significant central canal or neural foraminal narrowing. The bulges measure approximately 2 mm in size. 4. Generalized facetal arthropathy.

07/09/2013: MRI of cervical spine W/O contrast. **Impression:** 1. Broad-based posterior herniation of C5-6 disc, causing mild narrowing of central canal and neural foramina, bilaterally. The herniation measures approximately 4mm in size. 2. Diffuse bulge of C3-4, C4-5 and C6-7 discs, without any significant central canal or neural foraminal narrowing. The bulges measure approximately 2 mm and 3 mm in size, respectively. 3. Moderate generalized facetal and uncovertebral arthropathy.

07/14/2014: Progress notes. **HPI:** Claimant complains pressure neck, bilateral trapeszial and mild scapular pain. Claimant reported pain level 6/10. Alleviating conditions includes medications, stretching or exercise. Burning needle like lumbar pain that began since the injury was reported. The pain is constant, variable but easily reproducible with a baseline to changes. Claimant reports that PT was helpful. He also reported having 2 previous lumbar ESI. **Medications:** Tramadol, naproxen, simvastatin, Lisinopril, Glucotrol, Metoformin. **Plan:** Discussed the differential diagnosis that may be causing his symptoms. Chiropractic care has helped and should be continued. Claimant should continue taking the present analgesics and anti-inflammatory medications.

11/12/2014: MRI Lumbar spine W/O contrast. **Conclusion:** 1. Midline annular tear and mild disc bulge with mild spinal stenosis at L5-S1. This level is desiccated. 2. Moderate bilateral facet arthropathy at L4-5 with mild spinal canal stenosis. 3. Rest of the lumbar spine is unremarkable.

11/12/2014: MRI cervical spine W/O contrast. **Conclusion:** 1. Moderate spinal canal stenosis seen at C5-C6. 2. Mild spinal canal stenosis at C3-C4, C4-C5, and C6-C7. 3. Diffuse disc desiccation. 4. Cervical kyphosis between, C3 and C7.

12/19/2014: Progress Notes. Claimant reported pain level 2-6/10. **Plan:** Claimant continues to struggle with the recurrent both cervical and lumbar pain on a constant and variable basis. The upper extremities symptoms continue to be intermittent and not as aggressive than the legs. His legs have constant shooting pain that has forced him to become quite sedentary. Recommended a L4-5 and aL5-S1 medial branch block. Recommended a C5-6 and C6-7 medial branch block.

02/09/2015: UR. Rationale for denial: The patient sustained injury on xx/xx/xx, while materials and was struck by a fork lift and fell to the ground. The patient was diagnosed with lumbar sprain and strain, cervical sprain and strain. This is a request for central lumbar L-5-S1 epidural injection. Approve for treatment of severe LBP with radiculopathy, HPI and physical exam are indicative/supportive of diagnosis. Prior ESI had limited success. P2P call placed unable to reach provider. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for central lumbar L5-S1 epidural injection is non-certified.

02/12/2015: Office note. **Procedure Performed:** 1. Bilateral C5-6 facet injection. 2. Bilateral C6-7 facet injection.

02/24/2015: Progress Notes. Claimant reported the facet block injection gave him complete relief of the right-sided cervical pain with a 50% relief of the left side. Although there is only been a partial improvement the patient is happy with his results now that he is able to sleep through the night. Claimant reported he still struggles with the right leg radicular pain along the lateral aspect of the thigh and the left leg giving way on a regular basis. The claimant was diagnosis with lumbar sprain and strain, cervical sprain and strain. There was negative tenderness. The claimant had negative Patrick's test, Gaenslen's sign and pelvic tilt test. There was no pain throughout the arc of motion. Motor examination was normal. There was hypoesthesia noted on left L4. The claimant was attending chronic pain management therapy program. Number of visits completed not documented. The ROM did not elicit pain throughout the arc of motion. The Neurological examination revealed 5/5 motor strength in all muscle groups of the bilateral lower extremities. The deep tendon reflexes in posterior tibialis (L5) were graded 0/4 bilaterally. There was hypoesthesia in the anterior-lateral thigh and knee, medial leg and medial foot on the left along the L4 dematome. The straight leg raise was negative bilaterally. The cross SLT was negative bilaterally.

03/24/2015: UR. Rationale for denial: Patient had prior ESI more than 1 ½ years ago with minimal relief. There was a change in exam findings with worsening radicular pain. Patient has stenosis on imaging. There are reflex and sensory changes on exam. There was failure of medication, activity modification. The ESI is not medically necessary at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous determination is upheld. On the February 24, 2015 physical exam, the claimant did report right leg radicular pain along the lateral aspect of the thigh and the left leg giving way on a regular basis. The deep tendon reflexes in posterior tibialis (L5) were graded 0/4 bilaterally and there was hypoesthesia in the anterior-lateral thigh and knee, medial leg and medial foot on the left along the L4 dermatome. The MRI Lumbar spine on November 12, 2014 demonstrated disc bulge with mild spinal stenosis at L5-S1 and mild spinal canal stenosis at L4-5. ODG criteria for ESI states "Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented." Therefore, since MRI documented spinal stenosis, the request for Central Lumbar L5-S1 Epidural Injection does not meet ODG criteria and it not medically necessary at this time.

ODG Guidelines:

Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.
(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**